County of San Bernardino

F A S

STANDARD CONTRACT

FOR COUNTY USE ONLY

	New	Vendor Code	SC	Dept.	A	Contract Number
x	Change					94-150 A-2
	Cancel					

County Department	Dept.	Orgn.	Contractor's License No.
Arrowhead Regional Medical Center			

County Department Contract Representative	Telephone	Total Contract Amount
Margaret Smith, HRO II	580-1320	varies

Contract Type

☐ Revenue ☐ Encumbered ☒ Unencumbered ☐ Other:

If not encumbered or revenue contract type, provide reason:

Commodity Code	Contract Start Date	Contract End Date	Original Amount	Amendment Amount

Fund	Dept.	Organization	Appr.	Obj/Rev Source	GRC/PROJ/JOB No.	Amount
EAD	MCR	MCR	100	1010		varies
Fund	Dept.	Organization	Appr.	Obj/Rev Source	GRC/PROJ/JOB No.	Amount
Fund	Dept.	Organization	Appr.	Obj/Rev Source	GRC/PROJ/JOB No.	Amount

Project Name	Estimated Payment Total by Fiscal Year					
Home Health Care Registered Nurse	FY	Amount	I/D	FY	Amount	I/D

THIS CONTRACT is entered into in the State of California by and between the County of San Bernardino, hereinafter called the County, and

Name _____ Hereinafter called Contractor

Address _____

Telephone _____ Federal ID No. or Social Security No. _____

IT IS HEREBY AGREED AS FOLLOWS*:*

(*Use space below and additional bond sheets. Set forth service to be rendered, amount to be paid, manner of payment, time for performance or completion, determination of satisfactory performance and cause for termination, other terms and conditions, and attach plans, specifications, and addenda, if any.)*

AMENDMENT NO. 2

Agreement No. 94-150 shall be amended as follows, effective May 17, 2003:

1. **Amend** Section 7 under Compensation to read as follows:

   7. Contractor shall be reimbursed mileage at the IRS allowable rate, or thirty-six cents ($0.36) per mile, whichever is greater. Contractor shall begin counting mileage at their starting point, whether home or County Medical Center.

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All other terms and conditions of agreement 94-150 shall remain unchanged.
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/

COUNTY OF SAN BERNARDINO

► _____
Director and/or Designee, Arrowhead Regional Medical Center

Dated: _____

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD

Clerk of the Board of Supervisors
of the County of San Bernardino.

By _____
Deputy

_____
(Print or type name of corporation, company, contractor, etc.)

By: ► _____
(Authorized signature - sign in blue ink)

Name: _____
(*Print or type name of person signing contract)*

Title: _____
(Print or Type)

Dated: _____

Address: _____

_____

Approved as to Legal Form	Reviewed by Contract Compliance	Reviewed for Processing
►	►	►
County Counsel		Agency Administrator/CAO

Auditor/Controller-Recorder Use Only

☐ Contract Database	☐ FAS
Input Date	**Keyed By**

Date _____ | Date _____ | Date _____

Auditor/Controller-Recorder Use Only

☐ Contract Database	☐ FAS
Input Date	**Keyed By**